DHHS WAIVER ADVISORY COMMITTEE
MEETING MINUTES

Date: April 24, 2013 **Time**: 1:00 pm – 3:00 pm **Location**: NC Division of Public Health, Raleigh, NC

MEETING CALLED BY	Deby Dihoff, Chairman
TYPE OF MEETING	DHHS Waiver Advisory Committee (DWAC)

ATTENDEES

COMMITTEE MEMBERS			STATE STAFF ATTENDEES		
NAME	**AFFILIATION**	**PRESENT**	**NAME**	**AFFILIATION**	**PRESENT**
Peggy Terhune	Monarch	Exc.	Ken Marsh	DMHDDSAS – LME Team	☐
Margaret Stargell	Coastal Horizons Center, Inc.	☒	Kathy Nichols	DMA Waiver Pgms Mgr	☐
Jack Naftel, MD	NC Physicians Association	☒	Beverly Bell	DMA Contract Manager	☒
Rosemary Weaver	State CFAC	Call In			
Carol Messina	State CFAC	Call In			
Susan Monroe	Local CFAC	☒			
Marc Jacques	Local CFAC	☐			
Deby Dihoff	NAMI	☒			
Ellen Perry	IDD Advocate	Exc.			
Tony Sowards	SA Advocate	☒			
Cherene Allen-Caraco	Mecklenburg's Promise	☐	**GUEST**		
Lois Cavanagh-Daley	NC CANSO	☐	**NAME**	**AFFILIATION**	
Arthur C. Wilson	Transylvania Co.	☐			
Vacant	County Commissioner Assoc.	☐			
Brian Ingraham	Smoky Mtn. LME	Exc.			
Ken Jones	Eastpointe LME	☒			
Carol Steckel	DMA Director	☐			
Kelly Crosbie	Chief of DMA Operations	☒			
Jim Jarrard	DMH/DD/SAS Acting. Director	☒			
U. Nenna Lekwauwa	DMHDDSAS Medical Director	☐			

1. Agenda topic: Welcome and Approval of Minutes/Chair Housekeeping Items Presenter(s): Deby Dihoff

Discussion	• March 2013 minutes approved with no changes. • Calling In: Carol Messina, Rosemary Weaver • Location for next meeting Wake Commons, 4011 Carya Drive, Raleigh, NC 27610.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**
N/A		

2. Agenda topic: Partnership for a Healthy NC (formerly Medicaid Reform) Presenter(s): Kelly Crosbie, DMA

Discussion	• Principle goal is to provide a single portal of entry for individuals. The Comprehensive Care Entity (CCE) to serve as that portal.
	• Current system is complex and has multiple entry points.
	• CCEs to treat the whole person – physical, dental, mental, assistive medical equipment, etc., help access services from a wide spectrum.
	• Recipients will be able to choose their CCE based on their needs.
	• CCE will:
	  ○ Perform assessments to determine level of care (Comprehensive Assessment).
	  ▪ Assessments will not determine Medicaid eligibility but individual service eligibility.
	  ○ Develop a comprehensive provider list.

	○ Operate state-wide – provide services and options across the State ○ Pay capitation rate based on assessments and needs. • The emphasis is on how we make sure peoples' needs are addressed offering the right incentives and performance measures in contract. • This is not a budget exercise, it is not cuts. Rates are based on assessment and needs. As a result savings are expected. • Dollars can be used more creatively by CCE than by Medicaid. CCEs will have to provide basic expected benefits. • Not privatizing but private sector free to apply. • Does not change Medicaid eligibility • Does not expand Medicaid • Expanded to Statewide because that's what people asked for. • Why 3 CCEs – to promote competition/choice • Response to Questions: ○ CCE much like MCO but all services, not just behavioral health ○ Closer coordination of people in Behavioral Health with Physician. ○ There will be a broad RFP – not too specific, offer outcomes we expect, look at creativity of those interested ○ We learned a lot from MCOs regarding savings, giving back savings. Requirements to reinvest savings, cap on administrative dollars. Requirement to put percentage of savings back into services ○ How do we get to that one entry point? ▪ Rocky Thompson, DMA referred to Louisiana, Kansas ○ Do they have the types of services we provide? ▪ Rocky to get us the information. ○ Per CMS – access availability, under utilization measures to be addressed in contract. Services will be provided locally, not six hours away. ○ Providers in every area – CCEs don't have to be in that area. ○ How will it roll out for integrated care? Creates more flexibility for CCE to develop integrated care. ○ Ideal to have one Health Information Exchange (HIE). The state can't dictate that there be only one HIE.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**
□ Review service information from Louisiana and Kansas at future meeting.	Rocky Thompson	Next Mtg.

3. Agenda topic: LIP Representation within LME/MCO Provider Network **Presenter(s): Sally Cameron, NC Psychological Association Robin Huffman, NC Psychiatric Association**

Discussion	• Participation of Licensed Professional in private practice in Waiver system • NCPA acting as voice for LIPs, Professional Association Council – all licensed professionals. ○ Private practitioners are needed. ○ Losing experienced professionals ○ What will it take to retain: ▪ Standard enrollment, ▪ Standard Contract – update contract language. Wording not conducive to independent professionals. • Professionals cannot sign current contracts containing language "hold harmless" • New contract being developed expressly for independent professionals. ▪ Resolve Enrollment issues – have to enroll with everyone, enroll with DMA if Health Choice, labs having to enroll also. ▪ CAQH universal provider data source

	▪ Payment/billing processes too difficult, pay too low, payments not being paid. ▪ Value & Respect • Lack of awareness – these are licensed individual with rules and standards. • Fear of retribution on honest mistakes • Document shared from providers expressing concern. o Recommendation made to move away from presentations toward action • Concerns/Questions: o Ken Jones, LME/MCO Director, Eastpointe, requested copy of their presentation. Working to standardize process o Large systems have submitted many documents to try to promote standardization • Dan Coughlin – NC Council & MCOs clear there are myriad issues to tackle. They are committed to dealing with those issues. A large formal, public meeting is being planned with broad representation to fix this problem. • Advice from DWAC to the Department regarding LIP (vote taken twice, unanimous): 1. Include in the process of adopting the contract allowing the professional council review and input before adoption 2. CAQH requirement for all MCOs, with provision that some further research may be needed to fully understand credentialing requirements (agenda item) Other recommendations: o Standardize Contract o Centralized Billing System o Centralized electronic medical record system o Delegated contracting – individual with one MCO, other can accept that document and not have to start over again. ▪ Can't tell CMS what to do with Federal dollars. ▪ Work on accreditation piece if we can get around it
Conclusions	• Ellen Holliman to bring consultant that Alliance works with to assist with contract.

Action Items	**Person(s) Responsible**	**Deadline**
• Recommendations made to department and follow up requested by dept staff	Deby Dihoff	Next meeting

4. Agenda topic: LME/MCO Standardization practices across LME/MCOs **Presenter: Tom Savidge, CEO Port Human Services**

Discussion	• Private, Not for Profit, MH & SA provider serving Eastern Region of State • Stressed the difference between Private and Public in that the private practitioners need answers and resolutions today in order to provide timely services and survive. Public providers have other options and can afford to wait a little longer. • State fortunate to have MCOs. They are smart, and dedicated. • There is too much focus on problems. Evidenced based practice, QI show progress through MCOs. • Fear that building CCEs ok, but start up another story. Infrastructure should be put into place, then see if it works. Need to walk through, trial and errors. This must be done before implementing. o Duplication a problem. They work with 4 MCOs and have polled clients. There is duplication in business applications, policies and procedures. They have six different versions of their one policy. o Provider enrollment is not standard. Have two separate processes – one for agency to enroll, other for LIPs. o Applications are about 30 pages long – no consistencies. For example, a client moving to another service town will require reenrolling 18 clinicians in the 2nd facility. Everyone has to be enrolled. o Requesting single enrollment similar to colleges.

	○ Service Authorizations – need for them, helps with cost savings and quality care if done effectively. ○ Waste a lot of services ○ Basic benefit plans all different ▪ 24 managed visits vs 4 managed visits. Noted that rates can be lower than Medicaid rates – services can't be less than Medicaid requirements ○ Authorization process ○ Care Coordination ▪ Done by MCOs/private providers – lot of problems evolved. Suffering most in Care Coordination. More education needed to educate providers and consumers about role of Care Coordination. Consumers/families unaware of this and how to access. ▪ Care Coordinators don't have good knowledge of resources ▪ Care Coordination team meetings last hours. ▪ Need to develop system where reimbursement for services and educate on what the service does. ○ Paying claims tied into software systems. They are working with three different systems, costing more in administrative costs. ○ Want to see more cooperation when problems with claims billing/authorizations. It has always been the providers' responsibility to fix. ○ Specialized Services – CASP Cross Area Service Program. Good system care (SA issues). New system hasn't adapted. Crossing Co. of origin. Designed to take in people from all over. Very different to do now. Not recognized as specialty program. ○ Difficult case (17 yr. old) collaborated with MCO. Couldn't get authorization due to computer system at MCO down. Denied services. Glitch – girl had graduated, computer system knocked her out of the system. ○ These are Urgent needs
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**
• Continue to monitor our recommendations for standardization at each meeting, with a report on each area by Dept staff (Enrollment, Credentialing, LIP, Billing, Authorization, etc.)	Dept staff	Each meeting

5. Agenda topic: Other/Agenda **Presenter: Deby**

Discussion	• Advised the committee that the Secretary has not specifically addressed the role of DWAC, rather, is reviewing it along with all other Commission purposes. In process • Hold Appeals Process until next meeting • Add to agenda ○ How we are coming along on our recommendations for standardization (Dept staff to report) (also NC Council) ○ Presentation around achievements of Carve Out. Focus on successes like peer support, local accomplishments, funding of new services from savings, positive outcomes, use of differential rates ○ Jim to follow up on some of these ○ Memo – document good things – not let them go astray – 1115.
Conclusions	

Action Items	**Person(s) Responsible**	**Deadline**
• Staff to work with Deby on agenda • DWAC Members send agenda items	Assigned staff	5/15/13

6. Agenda topic: Public Comments **Presenter: Deby Dihoff**

Discussion	• Mary Short – Taylorsville, Alexander County ○ Addressing Sally/Robin – Noted that LME/MCOs request College Transcripts of provider staff. They also request school diplomas from families. ○ Regarding Enhanced Personal Care – Smoky had continued enhanced personal care and had heard that Smoky said they would pay. Providers have not been paid.

	○ Old CAP/MR/DD – 366 individuals were getting it. Hope division will get that paid. ○ PBH was the pilot for Waiver. Idea any one surprised not working, know PBH not doing it right. How did they handle LIPs. Shouldn't be surprised. PBH should have worked out the bugs. PBH sold bill of goods. Hope CCEs will do way better.		
Conclusions			
Action Items		**Person(s) Responsible**	**Deadline**
• Staff to follow up on Enhanced Personal Care.		Kelly	Next meeting

Meeting Adjourned
Next Meeting: Wednesday, May 15, 2013, 1:00 p.m. – 3:00 p.m. Wake Commons, 4011 Carya Drive.